DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99-10

2. STATE: N.C.

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JULY 1, 1999

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.325

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ 0
b. FFY _____ $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B
Section 19, Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B
Section 19, Page 2

10. SUBJECT OF AMENDMENT:
Payments for Medical and Remedial Care and Service.

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
N/A

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
H. David Bruton, MD

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Office of the Secretary
NC Department of Health & Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 3, 1999

18. DATE APPROVED:
June 28, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 1999

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Greiner

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

c. Case Management (Chronically Mentally Ill, Severely Disabled Children, Chronic Substance Abuse and Developmental Disabilities)

For services provided by DMH/MR/SAS:

Payment for case management services is based on an hourly rate. Effective with the 12 month period beginning July 1, 1999, and for subsequent 12 month periods, the rate paid is an interim amount that will be settled to cost . The interim rate is adjusted annually to equal the actual unit cost as determined in the cost analysis for the most recent year available. For payments to area mental health programs, cost determinations are based on weighted average unit cost for services as determined by the Division of Medical Assistance. Reasonable costs are determined by the Division of Medical Assistance based upon the standards set in OMB Circular A-87 and the HCFA-15 Provider Reimbursement Manual.

d. Case Management (Developmental Disabilities)

For services provided by DHS:

Reimbursement will be on a fee-for-service basis, billed monthly on the HCFA 1500 form. Payment will be the lesser of the charge or the establish fee. The fee will be set by dividing the cost of an FTE case manager by the caseload size. The fee will be evaluated annually and any overpayments will be recouped in the following year's rate. The state will not pay more than cost.

e. Case Management (Persons with HIV Disease)

Medicaid reimbursement for HIV case management services will be the same per unit rate (one unit =fifteen minutes) for all providers. Providers will be reimbursed the lower of usual and customary charges or a negotiated rate basis which will not exceed the upper limitation of 42 CFR 447.325. Governmental providers will be paid based on the above-negotiated rate not to exceed actual cost.